Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

BLOOD BANK SERVICES

Billing Instructions

July 1999

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About this publication

This publication supersedes all previous MAA Blook Bank Services Billing Instructions.

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Washington State Department of Social and Health Services
July 1999

Received too many billing instructions?
Too few?
Address Incorrect?

Please detach, fill out and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

How Do I Become A DSHS Provider?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H	(360) 664-0300
I-O	(360) 753-4712
P-Z	(360) 753-4711

Where Do I Send Hardcopy Claims?

Division of Program Support
PO Box 9248
Olympia WA 98507-9248

How Do I Request Billing Instructions?

Check out our website:

http://maa.dshs.wa.gov

or write/call:

Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800)-562-6188

Where Do I Call If I Have Questions Regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic Billing?

(360) 753-0318

or write to:

Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

Definitions

This section defines terms and acronyms used in these billing instructions.

Blood Bank - A health care facility that draws blood from voluntary donors, and tests, processes, stores, and distributes human blood and blood components.

Categorically Needy Program (CNP) – Federally-matched Medicaid program(s) that provide the broadest scope of medical coverage. Person may be eligible for CNP only or may also be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. CNP includes full scope of coverage for pregnant women and children.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement – A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department or DSHS – The Washington State Department of Social and Health Services. (WAC 388-500-0005)

Explanation of Benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fraud - An attempt to obtain benefits or payments in a greater amount than that to which a provider is entitled by means of:

(a) A willful false statement;
(b) Willful misrepresentation, or by concealment of any material facts; or
(c) A fraudulent scheme or device, including, but not limited to:
    (i) Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or
    (ii) Repeated billing for purportedly covered items, which were not in fact covered.

Internal Control Number (ICN) - A 17-digit number used to identify a claim. This number appears on the Remittance and Status Report near the client's name.

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With, or assigned to, a primary care provider;
- With, or assigned to, a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care.

(WAC 388-538-001).

Maximum Allowable – The maximum dollar amount MAA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320.

(WAC 388-500-0005)

Medical Assistance Administration (MAA) – The administration within the department of social and health services authorized to administer the acute care portion of the *Title XIX* Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medically Necessary – A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section "course of treatment" may include mere observation or, where appropriate, no treatment at all.
(WAC 388-500-0005)

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

a) "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
b) "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.
(WAC 388-500-0005)

Patient Identification Code (PIC) – An alphanumeric code that is assigned by MAA to each client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Program Support, Division of (DPS) – The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance and Status Report (RA) – A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Stat Charges – Stat charges are payable when sudden unexpected event occurs which requires immediate action and is needed to manage the patient in a true emergency situation. Limited to one STAT charge per episode; not once per test.

Third Party – Any entity that is, or may be, liable to pay all or part of the medical cost of care of a medical program client. (WAC 388-500-0005)

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment.

This rate *may not exceed*:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate for the same services normally offered to other contractors.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

Blood Bank Services

What services do blood banks offer?

Blood banks collect, process, store and supply blood and blood products to facilities that provide blood transfusions. The processing of blood includes all laboratory work required to prepare the product for use. Blood banks also provide blood transfusions if the client is in their facility and provide anti-hemophilic factor to hemophilic clients.

Who is eligible?

All Medicaid clients are eligible for Blood Bank Services.

Are managed care clients eligible?

Blood bank services are covered under managed care. Clients covered under managed care will have a Health Maintenance Organization (HMO) indicator in the HMO column on their MAID card. The managed care plan/provider must arrange or provide all services for a managed care client. The plan's 1-800 telephone number is located on the MAID card.

Coverage

What is covered? (WAC 388-87-045)

- MAA will pay for whole blood or blood derivatives only when they are not available to the patient from other sources.

  Limitations:

  - ✓ For clients who are covered by Medicare and Medicaid, MAA will pay up to the first three pints of blood or plasma in any spell of illness.
  - ✓ MAA will not pay for blood or blood derivatives that are donated.

- MAA will pay for the service charges necessary in handling and processing blood, plasma, or blood derivatives.

  Limitations:

  - ✓ If the patient is hospitalized, all charges must be included in the hospital's charges.
  - ✓ After-hours charges, "stat" charges, and weekend charges are not reimbursable.

- Administration of blood or blood derivatives on an outpatient basis in a hospital may be added to the total payment for outpatient service.

Billing

Billing for Blood Transfusions

- Health Care Financing Administration (HCFA) regulations require blood banks to bill the outpatient provider performing a blood transfusion for the blood product processing charge.
- Under Medicaid fee-for-service (FFS), the outpatient provider performing the transfusion must bill MAA for each unit of blood. The relevant blood product procedure codes and the current maximum allowable fees are listed in the fee schedule beginning on page 9.
- The HCPCS blood codes include the collection, processing, and storage of blood. The processing includes all lab work required to prepare the product for use.
- If a blood bank also performs (staff, physician, etc) blood transfusions in its facility, bill using the P-codes on page 16.

What is the time limit for billing?

State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days **after** you provide a service(s). Delivery of a service or product does not guarantee payment.
- **For clients who are <u>not</u> eligible at the time of service, but are later found to be eligible:** Bill MAA within 365 days from the Retroactive[1] or Delayed[2] certification period.

[1] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

- **MAA will not pay if:**

  - ✓ The service or product is not medically necessary;
  - ✓ The service or product is not covered by MAA;
  - ✓ The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; or
  - ✓ MAA is not billed within the time limit indicated above.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov, or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records does MAA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service(s) provided by the practitioner must be in chronological order. For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Quantity of medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying clients of their rights to make their own health care decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Fee Schedule

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief descriptions of CPT® procedure codes. To view the entire description, please refer to your current CPT® book.

CPT Code/ Modifier	Brief Description	July 1, 2002 Maximum Allowable Fee	
		Non-Facility Setting	Facility Setting
36415	Drawing blood	$2.45	$2.45
36430	Blood transfusion service	$22.75	$22.75
36450	Exchange transfusion service	$69.39	$69.39
36520	Plasma and/or cell exchange	$64.84	$64.84
38231	Stem cell collection	$48.69	$48.69
78120	Red cell mass, single	$46.87	$46.87
78120 26	Red cell mass, single	$7.51	$7.51
78120 TC	Red cell mass, single	$39.36	$39.36
78121	Red cell mass, multiple	$75.76	$75.76
78121 26	Red cell mass, multiple	$10.24	$10.24
78121 TC	Red cell mass, multiple	$65.52	$65.52
82143	Amniotic fluid scan	$6.83	$6.83
82247	Bilirubin, total	$4.59	$4.59
82248	Bilirubin, direct	$4.59	$4.59
82668	Assay of erythropoietin	$18.67	$18.67
82784	Assay of gammablobulin igm	$9.24	$9.24
82803	Blood gases: pH, pO2 & pCO2	$12.11	$12.11
83020	Hemoglobin eletrophoresis	$9.99	$9.99
83020 26	Hemoglobin electrophoresis	$12.51	$12.51
83030	Fetal hemoglobin, chemical	$8.22	$8.22
83890	Molecule isolate	$5.62	$5.62
83892	Molecular diagnostics	$5.62	$5.62
83894	Molecular gel electrophor	$5.62	$5.62
83896	Molecular diagnostics	$5.62	$5.62
83898	Molecular nucleic amplification	$23.52	$23.52
83912	Genetic examination	$5.62	$5.62

B.R. (*By Report)* - When you bill these codes, you must submit a report with your claim that documents the nature, extent, need, time, effort, and equipment necessary for the procedure or service. In some cases, you may also be required to provide additional information after MAA receives your claim.

NC – Not Covered

CPT Code/ Modifier	Brief Description	July 1, 2002 Maximum Allowable Fee Non-Facility Setting	Facility Setting
83912 26	Genetic examinations	$12.51	$12.51
84460	Alanine amino (ALT) (SGPT)	$5.26	$5.26
85002	Bleeding time test	$4.47	$4.47
85013	Hematocrit	$2.35	$2.35
85014	Hematocrit	$2.35	$2.35
85018	Hemoglobin	$2.35	$2.35
85210	Blood clot factor II test	$6.10	$6.10
85220	Blood clot factor V test	$16.18	$16.18
85230	Blood clot factor VII test	$13.86	$13.86
85240	Blood clot factor VIII test	$17.80	$17.80
85245	Blood clot factor VIII test	$22.81	$22.81
85246	Blood clot factor VIII test	$22.81	$22.81
85247	Blood clot factor VII test	$22.81	$22.81
85250	Blood clot factor IX test	$16.18	$16.18
85260	Blood clot factor X test	$17.80	$17.80
85270	Blood clot factor XI test	$16.18	$16.18
85280	Blood clot factor XII test	$19.23	$19.23
85290	Blood clot factor XIII test	$16.18	$16.18
85291	Blood clot factor XII test	$8.83	$8.83
85300	Antithrombin III test	$11.78	$11.78
85303	Blood clot inhibitor test, protein C	$13.74	$13.74
85305	Blood clot inhibitor assay, protein S	$11.52	$11.52
85306	Blood clot inhibitor test, protein S	$15.23	$15.23
85335	Iron stain, blood cells	$12.80	$12.80
85362	Fibrin degradation products	$6.84	$6.84
85366	Fibrinogen test	$8.56	$8.56
85370	Fibrinogen test	$11.29	$11.29
85378	Fibrin degradation	$7.09	$7.09
85384	Fibrinogen	$7.99	$7.99
85385	Fribrinogen	$7.99	$7.99
85410	Fibrinolytic antiplasminogen	$7.66	$7.66
85420	Fibrinolytic plasminogen	$6.50	$6.50
85460	Hemoglobin, fetal	$2.49	$2.49
85576	Blood platelet aggregation	$21.35	$21.35

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NC – Not Covered

CPT Code/ Modifier	Brief Description	July 1, 2002 Maximum Allowable Fee Non-Facility Setting	Facility Setting
85576 26	Blood platelet aggregation	$12.29	$12.29
85590	Platelet count, manual	$4.27	$4.27
85595	Platelet count, automated	$4.44	$4.44
85610	Prothrombin time	$3.90	$3.90
85635	Reptilase test	$8.69	$8.69
85660	RBC sickle cell test	$5.49	$5.49
85670	Thrombin time, plasma	$5.74	$5.74
85705	Thromboplastin inhibition	$9.38	$9.38
85730	Thromboplastin time, partial	$5.77	$5.77
85732	Thromboplastin time, partial	$6.44	$6.44
85999	Unlisted hematology procedure	B.R.	B.R.
86022	Platelet antibodies	$14.92	$14.92
86317	Immunoassay, infectious agent	$13.51	$13.51
86329	Immunodiffusion	$13.95	$13.95
86592	Blood serology, qualitative	$4.24	$4.24
86593	Blood serology, quantitative	$4.38	$4.38
86644	CMV antibody	$13.07	$13.07
86645	CMV antibody, IgM	$16.74	$16.74
86687	Htlv-i antibody	$8.34	$8.34
86688	Htlv-ii antibody	$13.93	$13.93
86701	HIV-1	$8.83	$8.83
86702	HIV-2	$13.44	$13.44
86703	HIV-1/HIV-2, single assay	$13.63	$13.63
86704	Hep b core antibody, total	$11.98	$11.98
86705	Hep b core antibody, igm	$11.70	$11.70
86706	Hep b surface antibody	$10.67	$10.67
86793	Yersinia antibody	$13.11	$13.11
86803	Hepatitis c ab test	$14.19	$14.19
86805	Lymphocytotoxicity assay	$21.41	$21.41
86821	Lymphocyte culture, mixed	$56.10	$56.10
86850	RBC antibody screen	$6.90	$6.90
86860	RBC antibody elution	B.R.	B.R.
86870	RBC antibody identification	B.R.	B.R.
86880	Coombs test	$5.33	$5.33

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NC – Not Covered

CPT Code/ Modifier	Brief Description	July 1, 2002 Maximum Allowable Fee Non-Facility Setting	Facility Setting
86885	Coombs test	$5.68	$5.68
86886	Coombs test	$5.14	$5.14
86890	Autologous blood process	$112.03	$112.03
86891	Autologous blood, op salvage	B.R.	B.R.
86900	Blood typing, ABO	$2.96	$2.96
86901	Blood typing, Rh (D)	$2.96	$2.96
86903	Blood typing, antigen screen	$9.38	$9.38
86904	Blood typing, patient serum	$9.45	$9.45
86905	Blood typing, RBC antigens	$3.47	$3.47
86906	Blood typing, Rh phenotype	$7.39	$7.39
86915	Bone marrow/stem cell prep	B.R.	B.R.
86920	Compatibility test	B.R.	B.R.
86921	Compatibility test	B.R.	B.R.
86922	Compatibility test	B.R.	B.R.
86927	Plasma, fresh frozen	B.R.	B.R.
86930	Frozen blood prep	B.R.	B.R.
86931	Frozen blood thaw	B.R.	B.R.
86932	Frozen blood freeze/thaw	B.R.	B.R.
86940	Hemolysins/agglutinins, auto	$8.15	$8.15
86941	Hemolysins/agglutinins	$12.03	$12.03
86945	Blood product/irradiation	B.R.	B.R.
86950	Leukacyte transfusion	$3.66	$3.66
86965	Pooling blood platelets	B.R.	B.R.
86970	RBC pretreatment	B.R.	B.R.
86971	RBC pretreatment	B.R.	B.R.
86972	RBC pretreatment	B.R.	B.R.
86975	RBC pretreatment, serum	B.R.	B.R.
86976	RBC pretreatment, serum	B.R.	B.R.
86977	RBC pretreatment, serum	B.R.	B.R.
86978	RBC pretreatment, serum	B.R.	B.R.
86985	Split blood or products	B.R.	B.R.
86999	Transfusion procedure	$12.99	$12.99
87340	Hepatitis b surface ag, eia	$10.26	$10.26
87390	Hiv-1 ag, eia	$17.53	$17.53

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NC – Not Covered

CPT Code/ Modifier	Brief Description	July 1, 2002 Maximum Allowable Fee Non-Facility Setting	Facility Setting
87391	Hiv-2 ag, eia	$17.53	$17.53
90281	Human ig, im	NC	NC
90283	Human ig, iv	NC	NC
90287	Botulinum antitoxin	NC	NC
90288	Botulism ig, iv	NC	NC
90291	Cmv ig, iv	NC	NC
90296	Diphtheria antitoxin	NC	NC
90371	Hep b ig, im	$126.88	$126.88
90375	Rabies ig, im/sc	$142.08	$142.08
90376	Rabies ig, heat treated	$149.52	$149.52
90378	Rsv ig, im, 50 mg	NC	NC
90379	Rsv ig, iv	NC	NC
90384	Rh ig, full-dose, im	NC	NC
90385	Rh ig, minidose, im	NC	NC
90386	Rh ig, iv	NC	NC
90389	Tetanus ig, im	NC	NC
90393	Vaccina ig, im	NC	NC
90396	Varicella-zoster ig, im	$111.25	$111.25
90399	Immune globulin	NC	NC
90780	IV infusion therapy, 1 hour	$25.48	$25.48
90781	IV infusion, additional hour	$12.74	$12.74
90782	Injection, sc/im	$2.50	$2.50
90783	Injection, ia	$9.33	$9.33
90784	Injection, iv	$10.92	$10.92
99195	Phlebotomy	$10.01	$10.01

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NC – Not Covered

HCPCS Code	Description	July 1, 2002 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
0800M*	Anti-hemophilic factor (e.g., Koate, Monoclate), per unit	$0.91	$0.91
0801M*	Stimate nasal spray, 2.5 ml bottle	$205.00	$205.00
P9010	Blood (whole), each unit	$55.11	$55.11
P9011	Blood (split unit), specify amount	B.R.	B.R.
P9012	Cryoprecipitate, each unit	$26.20	$26.20
P9016	Leukocyte poor blood, each unit	$45.53	$45.53
P9017	Plasma, fresh frozen, each unit	$47.82	$47.82
P9019	Platelet concentrate, each unit	B.R.	B.R.
P9020	Platelet, rich plasma, each unit	B.R.	B.R.
P9021	Red blood cells (RBC), packed cells, each unit	$66.64	$66.64
P9022	Washed RBC, washed platelets, each unit	$20.50	$20.50
P9023	Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	B.R.	B.R.
P9031	Platelets, leukocytes reduced, each unit	B.R.	B.R.
P9032	Platelets, irradiated, each unit	B.R.	B.R.
P9033	Platelets, leukocytes reduced, irradiated, each unit	B.R.	B.R.
P9034	Platelets, pheresis, each unit	B.R.	B.R.
P9035	Platelets, pheresis, leukocytes reduced, each unit	B.R.	B.R.
P9036	Platelets, pheresis, irradiated, each unit	B.R.	B.R.
P9037	Platelets, pheresis, leukocytes reduced, irradiated, each unit	B.R.	B.R.
P9038	Red blood cells, irradiated, each unit	B.R.	B.R.
P9039	Red blood cells, deglycerolized, each unit	B.R.	B.R.
P9040	Red blood cells, leukocytes reduced, irradiated, each unit	B.R.	B.R.
P9041	Infusion, albumin (human), 5%, 50 ml	B.R.	B.R.
P9042	Infusion, albumin (human), 25%, 10 ml	B.R.	B.R.
P9043	Infusion, plasma protein fraction (human), 5%, 50 ml	B.R.	B.R.
P9044	Plasma, cryoprecipitate reduced, each unit	B.R.	B.R.

*State-unique procedure code

B.R. (*By Report)* - When you bill these codes, you must submit a report with your claim that documents the nature, extent, need, time, effort, and equipment necessary for the procedure or service. In some cases, you may also be required to provide additional information after MAA receives your claim.

NC – Not Covered

HCPCS Code	Description	July 1, 2002 Maximum Allowable Fee Non Facility Setting	 Facility Setting
PROCESSING OF BLOOD DERIVATIVES			
Q0156	Infusion, albumin (human) 5%, 500 ml	Acquisition Cost	
Q0157	Infusion, albumin (human) 25%, 50 ml	Acquisition Cost	
Q0187	Factor VIIA (coagulation factor, recombinant) per 1.2 mg	$1,495.20	
J-CODES			
J0850	Injection, cytomegalovirus immune globulin intravenous (human), per vial	$598.15	
J1460	Injection, gamma globulin, intramuscular, 1 cc	$1.60	
J1470	Injection, gamma globulin, intramuscular, 2 cc	$3.20	
J1480	Injection, gamma globulin, intramuscular, 3 cc	$4.81	
J1490	Injection, gamma globulin, intramuscular, 4 cc	$6.41	
J1500	Injection, gamma globulin, intramuscular, 5 cc	$8.01	
J1510	Injection, gamma globulin, intramuscular, 6 cc	$9.61	
J1520	Injection, gamma globulin, intramuscular, 7 cc	$11.21	
J1530	Injection, gamma globulin, intramuscular, 8 cc	$12.82	
J1540	Injection, gamma globulin, intramuscular, 9 cc	$14.42	
J1550	Injection, gamma globulin, intramuscular, 10 cc	$16.02	
J1560	Injection, gamma globulin, intramuscular, over 10 cc	$16.02	
J1561	Injection, immune globulin, intravenous, per 500 mg	$40.05	
J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg (**Respigam only**)	$15.30	
J1670	Injection, tetanus immune globulin, human, up to 250 units	$106.80	
J2790	Injection, Rho (D) immune globulin, human, one dose package	$112.27	
J2792	Injection, Rho D immune globulin, intravenous, human solvent detergent	$21.07	

B.R. (*By Report)* - When you bill these codes, you must submit a report with your claim that documents the nature, extent, need, time, effort, and equipment necessary for the procedure or service. In some cases, you may also be required to provide additional information after MAA receives your claim.

NC – Not Covered

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How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide. A number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description/Instructions

1a. **Insured's I.D. NO.**: **Required**. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the medical assistance ID card (MAID). This information is obtained from the client's current monthly MAID card and consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: **Required**. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: **Required**. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, federal health insurance benefits, military and veteran's benefits) list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: **Required**. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. If the client has insurance secondary to the insurance listed in *field 11*, enter it here. When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9A. Enter the other insured's policy or group number *and* his/her Social Security Number.

9B. Enter the other insured's date of birth.

9C. Enter the other insured's employer's name or school name.

9D. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc. are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: **Required**. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11A. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11B. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11C. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11D. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d** is left blank, the claim may be processed and denied in error.

19. **Reserved for Local Use**: When applicable, enter indicator **B** t indicate Baby on Parent's PIC. If the client is one of twin or triplets, enter the **B** and indicate the client on the claim as "twin A or B" or "triplet A, B, or C," as appropriate.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1,2,3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only ONE (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 form.**

24A. **Date(s) of Service**: **Required**. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 04, 1999 = 070499).
Do not use slashes, dashes, or hyphens to separate month, day, year (MMDDYY).

24B. **Place of Service**: **Required**. The following is the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
3	Office or center
9	Other

24C. **Type of Service**: **Required**. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: **Required**. Enter the appropriate procedure code for the services being billed.

24E. **Diagnosis Code**: **Required**. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM or V58.2.

24F. **$ Charges**: **Required**. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: **Required**. Enter the total number of days or units for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Control Number.*

28. **Total Charge**: **Required**. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or patient paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: **Required**. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: **Required**. Put the name, address, and telephone # on all claim forms.

Group: Enter the group number assigned by MAA. This is the seven-digit number identifying the entity (i.e., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.